

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
4488		Item 9, Film G181 5-17-55 et				CERTIFICATE OF DEATH		Reg. Dist. No. 51			
1. PLACE OF DEATH:					2. USUAL RESIDENCE (HOME) OF DECEASED:						
COUNTY <u>Calvert</u>		MARYLAND			STATE <u>MD</u>		COUNTY <u>Calvert</u>				
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PARAN</u>						
X TOWN <u>Dr. Frederick</u>		<u>9 days</u>			STREET ADDRESS (If rural give location) <u>1</u>						
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>											
3. NAME OF DECEASED: (Type or Print)					(First)		(Middle)		(Last)		
<u>Emma</u>					<u>Brown</u>						
4. DATE (Month) OF DEATH: <u>5</u>		(Day) <u>7</u>		(Year) <u>1955</u>							
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MAR</u>		8. DATE OF BIRTH: <u>Dec 27, 1917</u>		9. AGE last birthday: <u>37</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>US</u>		
13. FATHER'S NAME: <u>George Harold</u>					14. MOTHER'S MAIDEN NAME: <u>Ethel Gross</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:				
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH						
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH											
<u>490X</u>											
IMMEDIATE CAUSE					(A) <u>Acute Nephritis</u>						
ANTECEDENT CAUSE (S)					DUE TO <u>Pneumonia</u>						
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.					(B) <u>Labor</u>						
					(C)						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.											
19A. DATE OF OPERATION: <u>0</u>					19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>4/29</u> 19 <u>55</u> , to <u>5/2</u> 19 <u>55</u> , that I last saw the deceased alive on <u>5/6/55</u> , 19 <u>55</u> , and that death occurred at <u>9:50</u> A M, from the causes and on the date stated above.											
SIGNATURE <u>[Signature]</u>			ADDRESS <u>[Address]</u>			DATE SIGNED <u>5/7/55</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)			DATE THEREOF		NAME OF CEMETERY OR CREMATORY			LOCATION (City, town, or county) (State)			
<u>5-10-55</u>			<u>5-10-55</u>		<u>St. Edmunds</u>			<u>Smith</u>			
DATE REC'D BY LOCAL REGISTRAR			REGISTRAR'S SIGNATURE			24. FUNERAL DIRECTOR			ADDRESS		
<u>5-10-55</u>			<u>N. W. Ward</u>			<u>P. E. Sewell, Prince Fred. Md.</u>					

BUREAU VI 3

MAY 12 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04479

4489

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Calvert</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Calvert</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Huntingtown</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert County Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print) <i>Sadie</i> (First) <i>Burton</i> (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <i>5</i> <i>2</i> <i>1955</i>			
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <i>wid</i>	8. DATE OF BIRTH: <i>11/23/1873</i>	9. AGE last birthday: <i>81</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired): <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Georgetown, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Richard Trail</i>				14. MOTHER'S MAIDEN NAME: <i>Mollie Ward</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>9</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Percy Burton - Huntingtown, MD</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <i>Cerebral hemorrhage</i>							
ANTECEDENT CAUSE (B) <i>Hypertension</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5/2</i> , 19 <i>55</i> , to <i>5/2</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>May 2</i> , 19 <i>55</i> , and that death occurred at <i>2:49</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>Richard Trail</i>		M.D. <i>St. Thomas</i>		DATE SIGNED <i>5/2/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>May 5 - 1955</i>		<i>Cedar Hill</i>		<i>Southland Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5-8-55</i>		REGISTRAR'S SIGNATURE <i>H. W. Ward</i>		24. FUNERAL DIRECTOR <i>Simmons Brothers</i>		ADDRESS <i>Ward, DC</i>	

BUREAU V. S.

MAY 5 1951

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04480

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

4490

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ch. Beach</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ch. Beach</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Samuel</u> (First) <u>LeRoy</u> (Middle) <u>Deets</u> (Last)		4. DATE OF DEATH <u>May</u> (Month) <u>21</u> (Day) <u>1955</u> (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M. Binnello</u>	8. DATE OF BIRTH <u>22 Oct 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>66</u> yrs. If under 1 year: Months <u>6</u> Days <u>21</u> Hours <u>19</u> Mins. <u>55</u>
11. BIRTHPLACE (State or foreign country) <u>Garrettsville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr F. Deets</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Gladden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>212-07-4176</u>	
17. INFORMANT AND ADDRESS <u>Mr Deets. Ch. Beach. Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of lung

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☐

22. I hereby certify that I attended the deceased from 7-24, 1954, to 5/20, 1955, that I last saw the deceased alive on 5/20, 1955, and that death occurred at 4:35 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. WeemsM.D. Huntingtown. Md.5/21/55

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 26/55Grace L. HutchinsRitchie Bros. Upper Marlboro, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 3 1965

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4491

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04481

CERTIFICATE OF DEATH

Item 9, Film 181 5-16-55 et

Reg. Dist. No. 51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert County</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Prince Frederick</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fairhaven</u>		<u>02x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location) <u>Anne Arundel Co.</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Laura A. Ferguson</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>5 2 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>		8. DATE OF BIRTH: <u>6-9-1872</u>	
9. AGE last birthday <u>82</u>		10. BIRTHPLACE (State or foreign country): <u>Virginia</u>		11. CITIZEN OF WHAT COUNTRY? <u>United States</u>		12. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>			
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Grandmother Rock</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT & ADDRESS: <u>Mr. Garrell Beitzell (son) Fairhaven, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>153X</u>							
ANTECEDENT CAUSE (S): (A) <u>Carcinoma of Bowell</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Due to</u>							
(C) <u>Due to</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1 Mo</u> , 1955, to <u>5/2</u> , 1955, that I last saw the deceased <u>alive on 5/2</u> , 1955, and that death occurred at <u>5:30</u> P. M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>5/2/55</u>			
M. D. <u>Huntington</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 5/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bedar Hill Cem</u>		LOCATION (City, town, or county) (State) <u>Prince Geo. Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-2-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Martin W. Ny Sing</u>		ADDRESS <u>1300 M. St N.W. Wash. D.C.</u>	

BUREAU V. S.

MAY 12 1955

RECEIVED

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04482

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 52

1. PLACE OF DEATH: COUNTY <u>Calvert</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Ches. Beach</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md</u> COUNTY <u>Calvert</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ches. Beach</u> <input checked="" type="checkbox"/> STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED: (Type or Print) <u>Nettie</u> (First) <u>Island</u> (Middle) <u>Island</u> (Last)		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>W</u>	8. DATE OF BIRTH: <u>Nov. 16, 1872</u>
9. AGE last birthday: <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Wid</u>	
11. BIRTHPLACE (State or foreign country): <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u>—</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Robert Buckmaster, Chesapeake</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
422.1 Immediate cause (a) <u>Acute dilatation of heart</u>		<u>1 hr</u>	
Antecedent cause(s) (b) <u>Chin. malarial</u>		<u>10 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Cardiomyopathy</u>		<u>12 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>1</u>		19b. MAJOR FINDING OF OPERATION: <u>Heart 4 km 5/25/55</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>H. W. Ward</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5/25/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>H. H. H. H.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>5/28/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Mt. Harmony Cem.</u>	LOCATION (City, town, or county) (State): <u>Mt. Harmony Md.</u>
DATE REC'D BY LOCAL REG. <u>May 28, 1955</u>	REGISTRAR'S SIGNATURE: <u>Grace L. Ketchum</u>	24. FUNERAL DIRECTOR: <u>H. H. H. H.</u> ADDRESS: <u>Owings, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 8 1955

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 52

05427

Item 9 Film 182 6-14-55 et

1. PLACE OF DEATH- COUNTY <u>Calvert</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Dunkirk</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS _____		MARYLAND LENGTH OF STAY <u>5 yrs</u> for this place		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Calvert</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dunkirk</u> OR TOWN <u>Dunkirk</u> STREET ADDRESS <u>Md</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Effie</u> (First) <u>Rogers</u> (Middle) <u>Jenkins</u> (Last)		4. DATE OF DEATH <u>May 29</u> (Month) (Day) (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) _____	8. DATE OF BIRTH <u>2 June 1888</u>	9. AGE last birthday <u>67</u> yrs. <u>66</u> yrs. <u>67</u> yrs. <u>68</u> yrs. <u>69</u> yrs. <u>70</u> yrs. <u>71</u> yrs. <u>72</u> yrs. <u>73</u> yrs. <u>74</u> yrs. <u>75</u> yrs. <u>76</u> yrs. <u>77</u> yrs. <u>78</u> yrs. <u>79</u> yrs. <u>80</u> yrs. <u>81</u> yrs. <u>82</u> yrs. <u>83</u> yrs. <u>84</u> yrs. <u>85</u> yrs. <u>86</u> yrs. <u>87</u> yrs. <u>88</u> yrs. <u>89</u> yrs. <u>90</u> yrs. <u>91</u> yrs. <u>92</u> yrs. <u>93</u> yrs. <u>94</u> yrs. <u>95</u> yrs. <u>96</u> yrs. <u>97</u> yrs. <u>98</u> yrs. <u>99</u> yrs. <u>100</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? _____		13. FATHER'S NAME <u>William Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Rogers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY No. _____		17. INFORMANT AND ADDRESS <u>Mrs. George J. Rogers</u> <u>Huntingtown, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) arteriosclerosis

(c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) _____

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY _____

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/1, 1947, to 5/29, 1955, that I last saw the deceased alive on 5/26, 1955, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 31, 1955
Grace L. Hutchins
St. James
Tracy's
Galleville, Md.

BUREAU V. S.

JUN 9 1965

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4493

CERTIFICATE OF DEATH

Reg. Dist. No. 51

04483

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL OR TOWN <u>Pr. Frederick</u>)		LENGTH OF STAY (in this place) <u>22</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pr. Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print) <u>Fred</u> (First) <u>Jones</u> (Middle) <u></u> (Last)				4. DATE OF DEATH: <u>5</u> - <u>7</u> - <u>1955</u> (Month) (Day) (Year)			
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH:		9. AGE last birthday <u>72</u> yrs	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Calvert Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Charles Jones</u>				14. MOTHER'S MAIDEN NAME: <u>Georganna Dawkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>1</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-14-7203</u>		17. INFORMANT & ADDRESS: <u>MAZIE MACKALL - Pr. Frederick</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
782.4 IMMEDIATE CAUSE (A) <u>Congestive - Heart failure</u>							
ANTECEDENT CAUSE (S) (B) <u>Malnutrition</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 10</u> , 19 <u>55</u> , to <u>May 7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 7</u> , 19 <u>55</u> , and that death occurred at <u>12:30</u> P, from the causes and on the date stated above.							
23. (BURIAL) CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>5-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>Carroll</u>		LOCATION (City, town, or county) (State) <u>Barstow, Calvert Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-10-55</u>		REGISTRAR'S SIGNATURE <u>N.W. Ward</u>		24. FUNERAL DIRECTOR <u>P.E. Sewell</u>		ADDRESS <u>Prince Fred, Md</u>	

42

SSC

4494

04484

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Cecil</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>Cecil</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Henricton</i>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) <i>Henricton</i>	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Joseph</i>	(Middle) <i>Jones Jr</i>	(Last)	(Month) <i>5</i> (Day) <i>2</i> (Year) <i>1955</i>
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>W</i>	8. DATE OF BIRTH: <i>Dec 26 1877</i>
9. AGE last birthday: <i>77</i> yrs.		10. IF UNDER 1 YEAR: Months <i>5</i> Days <i>2</i> IF UNDER 24 HRS. Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>farmer and owner</i>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. FATHER'S NAME: <i>Joseph Jones</i>		12. CITIZEN OF WHAT COUNTRY?	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME: <i>Julia Foster</i>	
15. SOCIAL SECURITY No.:		16. INFORMANT & ADDRESS: <i>Mrs Joe Jones</i>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
4343 Immediate cause (a) <i>Acute dilatation of heart</i>			
Antecedent cause(s) (b) <i>giving rise to the above cause</i>			
DUE TO (c) <i>stating underlying cause last</i>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <i>fat up & voided, fell in floor & died</i>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town), (County)	(State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>5 2/55 630 A.M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE: <i>H.W. Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>5/2/55</i> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF: <i>5-4-55</i>	NAME OF CEMETERY OR CREMATORY: <i>Paterpent</i>	LOCATION (City, town, or county) (State) <i>Henricton Md</i>
DATE REC'D BY LOCAL REG. <i>5-3-55</i>	REGISTRAR'S SIGNATURE: <i>H.W. Ward</i>	24. FUNERAL DIRECTOR: <i>P.E. Sewell Prince Frederick 2nd</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

4495

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04485

CERTIFICATE OF DEATH

Reg. Dist. No.

5-1

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cabot</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cabot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Prince Frederick</u>		<u>1 mo.</u>		TOWN <u>Solomons</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cabot County Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>Eliza</u> (Middle) <u>E</u> (Last) <u>Jusky</u>				(Month) <u>May</u> (Day) <u>6</u> (Year) <u>1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>		8. DATE OF BIRTH: <u>Nov. 14, 1868</u>	
				9. AGE last birthday: <u>86</u> yrs. <u>6</u> months <u>22</u> days <u></u> hours <u></u> min.			
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>St. Mary's Co., Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.O</u>							
13. FATHER'S NAME: <u>Alvin Readmond</u>				14. MOTHER'S MAIDEN NAME: <u>Mary G. Jusky</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO.: <u>No</u>		17. INFORMANT & ADDRESS: <u>Gray G. Jusky - Solomons, Md</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
466X Immediate cause (a) <u>Heart failure</u>							
Antecedent causes (s) (b) <u>thrombosis of left leg</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY ?				Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	
SUICIDE		OF INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>5/6</u> , 19 <u>55</u> , to <u>5/8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/6</u> , 19 <u>55</u> , and that death occurred at <u>9 am</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>5/20/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		<u>May 9, 1955</u>		<u>Solomons M.E. Cem.</u>		<u>Solomons - Cabot Co., Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-9-VJ</u>		<u>H. W. Ward</u>		<u>A. A. Harkness & Son - Mutual, Ind.</u>			

BUREAU V. S.

MAY 10

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4496

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04486

CERTIFICATE OF DEATH

Reg. Dist. No.

Calvert Co. Hosp.

1. PLACE OF DEATH:

COUNTY Calvert MARYLAND
CITY (If outside corporate limits, write RURAL) LENGTH OF STAY
OR (and give nearest town) (in this place)
X TOWN Prince Frederick 6 days

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS614 Calvert Co. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY Calvert
CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN BAYSTON X
STREET ADDRESS (If rural give location)
MD

3. NAME OF
DECEASED:

(First) (Middle) (Last)
CHARLOTTE MAC Gruder

4. DATE (Month) (Day) (Year)
OF DEATH: 5 16 1955

5. SEX:

F6. COLOR OR
RACE:N7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):Married

8. DATE OF BIRTH:

Aug 1, 1899

9. AGE last birthday:

55 yrs

IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):House wife10B. KIND OF BUSINESS
OR INDUSTRY:MD

11. BIRTHPLACE (State or foreign country):

MD12. CITIZEN OF WHAT
COUNTRY?MD

13. FATHER'S NAME:

Thomas Purvey

14. MOTHER'S MAIDEN NAME:

Harriet Norris15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates
of service)Yes

16. SOCIAL SECURITY NO.

Daither Thomas Prince Frederick

17. INFORMANT & ADDRESS:

Daither Thomas Prince Frederick

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(A)
DUE TO(B)
DUE TO

(C)

Cerebral hemorrhage
Essential Hypertension

INTERVAL BETWEEN
ONSET AND DEATHII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

M.

21E. INJURY OCCURRED
While ☐ Not while ☐
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 10, 1955, to May 16, 1955, that I last saw the deceased
alive on May 16, 1955, and that death occurred at 9:50 M., from the causes and on the date stated above.

SIGNATURE

Dr. Leonard S. J. Hemm

M. D.

ADDRESS

Prince Frederick

DATE SIGNED

5/16/5523. (BURIAL) CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

5-18-55

NAME OF CEMETERY OR CREMATORY

Green Point

LOCATION (City, town, or county)

Calvert

(State)

MDDATE REC'D BY LOCAL
REGISTRAR5-16-55

REGISTRAR'S SIGNATURE

W. C. Ward

24. FUNERAL DIRECTOR

P. E. Sewell

ADDRESS

Prince Frederick

BUREAU OF

MAY 23 195

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4497

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04487

CERTIFICATE OF DEATH

Reg. Dist. No.

52

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Calvert</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Calvert</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<i>x</i> TOWN <i>Prince Frederick</i>		TOWN <i>Rural. Paris Md. x</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<i>64 Calvert Co. Hospital</i>			
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Archie</i>	(Middle) <i>Pembroke</i>	(Last) <i>Norfolk</i>	(Month) <i>May</i> (Day) <i>13</i> (Year) <i>1955</i>
(Type or Print)			
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>March 10, 1889</i>
			9. AGE last birthday: <i>66</i> yrs. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.
10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Farming</i>		11. BIRTHPLACE (State or foreign country): <i>Calvert Co. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME: <i>John H. Norfolk</i>		14. MOTHER'S MAIDEN NAME: <i>Annie Griffith</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>4</i>		16. SOCIAL SECURITY No.: <i>—</i>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <i>Mrs Carl Denton, Dwings Md</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
434.3 Immediate cause (a) <i>Acute dilatation of heart</i>		<i>40 min</i>	
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO			
(c) <i>went to bed and was taken in 5 min. Died enroute to Hospital</i>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11/20/55</i> , 19 <i>55</i> , to <i>5/14/55</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>11/20/55</i> , 19 <i>55</i> , and that death occurred at <i>11/20/55</i> , from the causes and on the date stated above.			
SIGNATURE <i>H. H. H. H. H.</i>		ADDRESS <i>5/14/55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>May 16, 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>W. H. H. H. H.</i>		LOCATION (City, town, or county) (State) <i>Dwings Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>May 16, 1955</i>		REGISTRAR'S SIGNATURE <i>Grace L. Hutchins</i>	
24. FUNERAL DIRECTOR <i>W. H. H. H. H.</i>		ADDRESS <i>Dwings Md</i>	

MAY 15

RECEIVED

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05432
Reg. Dist.

No. 52

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Calvert</u>	MARYLAND	STATE <u>Pa</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Belleville</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Belleville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Collier's Funeral Home</u>		STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED: (Type or Print) <u>Collier's Linnie Phibyan</u>	4. DATE OF DEATH 5-22-55
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>	8. DATE OF BIRTH: <u>1908</u>
9. AGE last birthday: <u>47</u> yrs.	10. IF UNDER 1 YEAR: <u>5</u> Months <u>22</u> Days
	11. IF UNDER 24 HRS. <u>19</u> Hours <u>55</u> Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>	11. BIRTHPLACE (State or foreign country): <u>Pa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Samuel Milton Phibyan</u>	14. MOTHER'S MAIDEN NAME: <u>Sarah Pauline Phibyan</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>unk</u>	16. SOCIAL SECURITY NO.: <u>unk</u>
17. INFORMANT & ADDRESS: <u>Arthur Phibyan</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause: <u>Heart</u>	DUE TO	<u>5/24/55</u>
(b) Antecedent cause(s): <u>Found 6/1/55 at 10 AM</u>	DUE TO	
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH: <input type="checkbox"/>	21b. PLACE (Home, farm, factory, office bldg., etc.) OF INJURY: <u>Home</u>	21c. City or town: <u>Calvert</u> County: <u>Pa</u> (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>5-22-55 3 PM</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Mixed off lat</u>

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: H. W. Wang CHIEF MEDICAL EXAMINER ☐ DATE SIGNED: 5/1/55
DEPUTY MEDICAL EXAMINER ☐
M. D. ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>6/1/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Comfort Club</u>	LOCATION (City, town, or county) (State): <u>Calvert Pa.</u>
DATE REC'D BY LOCAL REG. <u>June 1, 1955</u>	REGISTRAR'S SIGNATURE: <u>Grace L. Nuttall</u>	24. FUNERAL DIRECTOR: <u>Cunningham Funeral Home</u>	ADDRESS: <u>Belleville Pa.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



4498

04488

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 51

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Calvert</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Calvert</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>H. Beach Md</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>H. Beach Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (First) <u>Harry C.</u> (Middle) <u>Ranch</u> (Last) <u>Quack</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>W</u>	8. DATE OF BIRTH: <u>June 2, 1875</u>
9. AGE last birthday: <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, if any): <u>Registered yard</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Md</u>	
11. BIRTHPLACE (State or foreign country): <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Charles Ranch</u>		14. MOTHER'S MAIDEN NAME: <u>Haverth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give year or dates of service) <u>1918-1919</u>		16. SOCIAL SECURITY No.: <u>7-3444</u>	
17. INFORMANT & ADDRESS: <u>Carrie Boccek, H. Beach</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Acute dilatation of heart</u>			
Antecedent cause(s) (b) <u> </u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u> </u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u> </u>			
19a. DATE OF OPERATION: <u> </u>		19b. MAJOR FINDING OF OPERATION: <u> </u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY: <u>Home</u>	21c. (City or town) <u>H. Beach</u> (County) <u>Calvert</u> (State) <u>Md</u>	
21d. TIME (Month) <u> </u> (Day) <u> </u> (Year) <u> </u> (Hour) <u> </u>	21e. INJURY OCCURRED While at <u> </u> work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u> </u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Howard R. M. E.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5/5/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u> </u>	DATE THEREOF: <u>5/5/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Cedar Hill</u>	LOCATION (City, town, or county) (State) <u>Wash DC</u>
DATE REC'D BY LOCAL REG. <u>5/5/55</u>	REGISTRAR'S SIGNATURE <u>Howard</u>	24. FUNERAL DIRECTOR <u>Beal</u>	ADDRESS <u>Wash DC</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. A.

MAY

1950

4499

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04489

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>North Beach</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
TOWN <u>North Beach</u> LENGTH OF STAY (in this place) <u>1 yr.</u>		TOWN <u>Washington D.C.</u> 47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1404-8th St</u>		STREET ADDRESS (If rural give location) <u>1806-28th St. S.E.</u>	
3. NAME OF DECEASED (Type or Print) <u>Benny</u> (First) <u>E</u> (Middle) <u>Lucas</u> (Last)	4. DATE OF DEATH <u>May 7</u> 19 <u>55</u>	5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, (DIVORCED) (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2/10/1901</u>	9. AGE last birthday <u>54</u> yrs. <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sound</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Pub. Jail</u>	11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Edward Lucas</u>	14. MOTHER'S MAIDEN NAME <u>Mary Brough</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If year, give war or dates of service) <u>#2</u>	16. SOCIAL SECURITY No. <u>#2</u>	17. INFORMANT <u>Edward Smith</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>420.1</u> (a) <u>Coronary occlusion</u>			
Antecedent cause(s) _____			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last _____ (b) _____		(c) _____	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>5/2</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 7/1, 1954, to 5/6, 1955, that I last saw the deceased alive on 4/29, 1955, and that death occurred at 4:24 m., from the causes and on the date stated above.

SIGNATURE <u>R. Lucas</u> (Degree or title)	ADDRESS <u>Washington D.C.</u>	DATE SIGNED <u>5/7/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>5/11/55</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington</u>
LOCATION (City, town, or county) <u>Washington D.C.</u>	(State) <u>D.C.</u>	24. FUNERAL DIRECTOR <u>Robert A. Mattingly</u>
DATE REC'D BY LOCAL REG. <u>May 7, 1955</u>	REGISTRAR'S SIGNATURE <u>Grace L. Kitchin</u>	ADDRESS <u>131-11th St. S.E. Wash. D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 12 1955

RECEIVED

4500

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Lower Marlboro</u>		<u>53</u> years		TOWN <u>Lower Marlboro</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
(Type or Print) <u>Caroline</u>		<u>Elizabeth</u> <u>Wells</u>		<u>May</u> <u>8</u> <u>19</u> <u>55</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>Married</u>		<u>April 16, 1871</u>	
						9. AGE last birthday: <u>84</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>----</u>		<u>Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Alexander Fowler</u>				<u>Ann Buckler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>----</u> (If Yes, give war or dates of service)		<u>----</u>		<u>Mr. Oliver Wells, Lower Marlboro, Md.</u>			
18. MEDICAL CERTIFICATION							
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
600.0 Immediate cause (a) <u>Recurrent Pyelonephritis</u>						<u>25 years.</u>	
Antecedent causes (s) (b) <u>Hypertension</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		OF INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>May 6, 1955</u> , to <u>May 8, 1955</u> , that I last saw the deceased alive on <u>May 6, 1955</u> , and that death occurred at <u>5 pm</u> from the causes and on the date stated above.							
SIGNATURE (Degree or title)				ADDRESS DATE SIGNED			
<u>Grace L. Hutchins</u>				<u>Lower Marlboro, Md.</u> <u>5/9/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 10, 1955</u>		<u>Lower Marlboro Cemetery</u>		<u>Lower Marlboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>May 10, 1955</u>		<u>Grace L. Hutchins</u>		<u>William H. Hutchins, Owings, Maryland</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 16 1955

RECEIVED